that Dr. Benjamin Katz rendered medical aid to the best of his ability."

From an etiologic point of view the writer's case closely resembles Schrotter's and Husik's cases, namely, the patient having a chronic catarrh of the intestines associated with an enlarged thymus and spleen (status lymphaticus) developed about two hours after tonsillectomy, an acute fatal edema of the larynx.

PATHOLOGY

Hajek experimentally demonstrated by injection of liquids into the larynx of a cadaver that edema spreads according to certain laws. The great vascularity of the larynx, together with the fact that the blood vessels of the mucous membrane are practically unsupported, permits rapid congestion, and there is a leakage into the perivascular tissue. The exuded serum fills the intercellular spaces and lymph channels, giving them an appearance of a semitransparent swelling. There is no inflammation present. According to several case reports proven clinically and microscopically, the edema of the larynx can be accompanied by simultaneous edema of the brain, probably involving the respiratory and cardiac centers.

DIAGNOSIS

Presence of a semitransparent swelling in the larynx without any inflammatory condition, accompanied by signs of difficulty in breathing, makes the diagnosis possible when the progress of the edema is slow. In rapidly developing cases of edema the symptoms of general collapse prevail, the edema being detected only after death.

TREATMENT

C. Theisen, who had a few cases of edema of the larynx under his observation, recommends a cold spray of adrenalin 1 : 5000 and an ice coil around the neck. When difficulty in breathing develops, incisions with the Schrotter-guarded laryngeal knife or a tracheotomy is indicated. It is worth while to mention that in rapidly progressing edema of the larynx the patient may die before a tracheotomy can be performed, or even when a tracheotomy has been done, if edema involves the brain.

SUMMARY

Acute angioneurotic edema of the larynx is a rare but very dangerous complication, which, in our present knowledge, can neither be foreseen nor prevented. Its etiology is obscure. In recorded cases inherited nervous conditions, gastric disturbances, focal infection, endocrine disorders, malnutrition, and anaphylactic disturbances have been noted. The treatment indicated often fails because of the rapidity of involvement or because of edema of the brain. The literature of the subject is very scanty. Therefore all cases should be reported in order that further data may be collected for study.

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A NEW GLASS DRAINAGE TUBE FOR SUPRAPUBIC PROSTATECTOMY

By L. Lore Riggin
Pasadena

Drawing, to scale, of a glass drainage tube for use in suprapubic prostatectomy cases. The drawing is self-explanatory.

Advantages claimed over the Freyer tube are:

1. By the two "arm" outflow, the patient may lie on either side without disturbing the drainage.

2. The two "arm" supports on the dressings, make a more comfortable dressing for the patient.

3. By the "through-and-through" opening of the large tube, obstructing clots may be attacked by alligator forceps and be removed.

4. Through this same avenue the catheter may be passed when doing the postoperative irrigations of the bladder.

5. Free exit of urine and irrigating solutions is possible without soiling the dressings, and without causing tension on the bladder walls, and without changing position of the patient.

6. Much easier postoperative care of the bladder with the least discomfort to the patient.

The large upper opening is kept closed with a rubber stopper when not used; each side "arm" has a length of soft rubber tubing attached, with a glass connection on the distal end for making connection with the tubing leading to the reservoir (connection being made with the dependent one).

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